	HOUSE: HR 676	SENATE: ~~Medicare for All Act~~S 1804
Universality	All residents as defined by Sec. HHS, presumed eligible when present for care.	All residents as defined by Sec. HHS when fully implemented (4 years after passage), doesn't presume inclusion.
Coverage	"All medically necessary care" Includes primary care and prevention, nutrition, inpatient, outpatient, emergency, pharmaceuticals, medical equipment, long term care, palliative care, mental health, dental, substance abuse treatment, chiropractic, vision, hearing, podiatry. Prioritizes in-home and community-based care.	Covered services "if medically necessary or appropriate" Includes primary care and prevention, inpatient, outpatient, emergency, pharmaceutical (specifies biologicals), medical devices, mental, substance abuse treatment, labs and diagnostics, comprehensive reproductive care, dental, hearing and vision, short-term rehabilitative care.
Long Term Care	Covered.	Remains in Medicaid, administered by the states.
Adding benefits	No specific mechanism, perhaps under recommendation of the National Board of Universal Quality and Access (NBUQA).	Specifies adding appropriate complementary and integrative practices and overcoming barriers to care. Includes appeals process.
Cost sharing	None.	Co-pays on pharmaceuticals with exceptions, cap of $200/year.
Choice of provider	Choice of all participating providers in US and territories.	Choice of all participating providers in US and territories.
Providers	All who meet standards and are public or nonprofit (bans investor-owned facilities and phases them out over 15 years). All facilities must meet standards for staffing and quality.	All who meet standards. Includes investor-owned facilities. All facilities must meet standards of staffing, competence, quality and satisfaction.
Opt - out	Not specified.	Providers may opt out but must do so completely. Patients may purchase covered services from providers that opt out and still be covered for other services in the system.

Duplication	No private insurance or HMO that operates as a private insurance can duplicate coverage.	No private insurance can duplicate coverage.
Supplemental insurance	Enrollees can purchase supplemental insurance.	Enrollees can purchase supplemental insurance.
Payment for services	Fees negotiated with NBUQA with input from state physician review boards, determined regionally, paid within 30 days. Alternatives are salary for an institution and capitated payment.	Fees set by Sec. HHS with input, based on current Medicare structure. Includes innovation within MACRA.
Administration	Sec. HHS appoints a general director who appoints long term care and mental health care directors and director for Office of Quality Control, who consults with regional and state directors. State physician review boards. NBUQA is a 15-member stakeholder board appointed by President with Senate approval.	Sec. HHS oversees the entire system and may consult with other agencies and stakeholders. Sec. HHS appoints regional and state directors, regional directors to represent Native American and Native Alaskan tribes, Omsbudsman.
Operating and capital expense budgets	Global operating budgets for each facility and separate capital expense budgets, cannot co-mingle.	No global operating budgets. Facilities can co-mingle operating and capital budgets. No mechanisms to control budgets.
Health Professional Education	Included in general budget.	Included in general budget. Establish Office of Primary Care in AHRQ to expand access to primary care.
Prices for goods	Pharmaceutical, medical supplies and equipment negotiated annually, formulary.	Pharmaceutical, medical supplies and equipment negotiated annually, formulary.
Transition for workers	Displaced workers have first priority to be hired into new system, 2 years salary and training support.	Temporary worker assistance for up to 5 years, capped at 1% of total budget.
Health records	Confidential electronic records, patients can withhold electronic sharing.	Not specified.
Health planning	Annual review. Recommendations come from the states and Office of Quality Control.	Annual review. Audit every 5 years. Input comes from state directors and others as requested.

Veterans/Indian Health	VA/ IHS separate at first. Integrate IHS after 5 years. Evaluate inclusion of VA after 10 years.	VA/IHS remain separate.
Quality control	NBUQA (diverse membership), long term and mental health directors, director of Office of Quality control, regional and state directors all monitor, report, make suggestions and implement.	Overseen by Sec. HHS with input, mechanism for enrollees to appeal and to protect whistleblowers who report violations.
Funding	Medicare Trust Fund includes current public health dollars, various taxes on wealthy, payroll tax. Additional annual sums as necessary.	Medicare Trust Fund includes current public health dollars, otherwise not defined. Reserve fund for emergencies such as epidemics and natural disasters.
Fraud and abuse	Not defined.	As per the Social Security Act.
Start of system	On January 1 of the first year that is more than a year after passage of the Act.	Transition phase begins on January 1 of the first year after passage of the act and lasts 4 years (see chart).
Transition	None. Everyone is in the system when it begins.	Multi-payer system over first 4 years that phases people into a universal single payer system when complete.